

RI Department of Health

Application and Instructions for:



Resort, Lodging, Camp

Applicant Name (Name of Business)

Previous Business Name & License Number (If Any) at this address

OFFICE USE ONLY

	Initials	Date
Approved by F.O. Supervisor		
Profile Entered By		
License ID#		
Receipt No.		
License No.		

INSTRUCTIONS

- Registration shall be based upon **Satisfactory Compliance** with all applicable laws and regulations.
- Registration forms must be either typed or legibly printed using a ball point pen, except signatures, which must be written in ink. Please answer all questions. Do not leave blanks. Incomplete applications will be returned to you and your license/permit will not be issued.
- Attach check/money order to the front of this application and mail to: Office of Food Protection, 3 Capitol Hill, Room 203, Providence, RI 02908-5097. Please do not hand deliver this form to the Department of Health. A receipt or cancelled check does not guarantee licensure.

Application Fees:

Resort, Lodging, Camp

\$120.00

- Make your check/money order payable to "General Treasurer, State of Rhode Island". Do not send cash.
- If you have any questions concerning this application, call the Department of Health, Office of Food Protection at (401) 222-2749.
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

Please complete the section(s) below.

Food Service :	<input type="checkbox"/> Food Service Available – (* See Below) <input type="checkbox"/> Food Service Not Available <small>*Note – If food is being served at this location, you must also possess a valid, active Food Service (FSV) license to operate.</small>
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State of Rhode Island and Providence Plantations
Department of Health
Office of Food Protection

Facility Name:

Please provide the name of the facility (as known to the public) for which you are applying for this license.

Name: _____

Facility Contact Person:

Please provide the name and telephone number of a person we can contact concerning this facility.

Name: _____

Phone Number:

() _____

Facility Mailing Information:

Please provide the mailing information for all communication regarding this license.

(Not published on HEALTH website).

Address Line 1 _____

Address Line 2 _____

Address Line 3 _____

City, State, ZipCode _____

Country (only if not in US) _____

Phone: _____

Fax: _____

Email Address: _____

Facility Location Information:

Please provide the location information for this facility.

(Published on HEALTH website)

Address Line 1 _____

Address Line 2 _____

Address Line 3 _____

City, State, ZipCode _____

Country (only if not in US) _____

Phone: _____

Fax: _____

Email Address: _____

Ownership Type :

Please check ONE

☐

Corporation

☐

Limited Liability Company

☐

Governmental Entity

☐

Sole Proprietorship

☐

Partnership

☐

Limited Partnership

☐

Partner

Ownership Information:

Please provide the ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.

LIST ONE ONLY - DO NOT SEND ATTACHMENTS

Name: _____

DBA (Doing Business As): _____

Ownership Address Information: Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ City, State, Zipcode _____ Phone: _____ Fax: _____ Email Address: _____
Water Supply:	Does this establishment receive all or a portion of its water supply from an on-site well? <input type="checkbox"/> Yes <input type="checkbox"/> No
Sewage System:	Is this establishment serviced by a private sewage system (e.g. septic system)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Campground Housing Units and Camp Sites:	Please indicate the number of housing units. _____ Please indicate the number of camp sites. _____
Person Capacity:	What is the daily person capacity for the facility? _____
Swimming:	Please indicate swimming availability below: <input type="checkbox"/> Pool <input type="checkbox"/> Stream <input type="checkbox"/> Ocean <input type="checkbox"/> Pond <input type="checkbox"/> No Swimming Available
Seasonal Operational Dates:	If this is a seasonal operation, please indicate dates below: Open on: _____ Close on: _____ month/day/year month/day/year
Affidavit of Applicant Read, sign, and date this affidavit.	<div style="text-align: center;">AFFIDAVIT AND SIGNATURE</div> <p>I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.</p> <p>I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 60%;"> <p>_____ Signature of Authorized Person</p> <p>_____ Printed Name of Authorized Person</p> <p>_____ Title of Authorized Person</p> </div> <div style="width: 35%; text-align: center;"> <p>_____ Date of Signature (MM/DD/YY)</p> </div> </div>